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ABSTRACT

This paper discusses issues and offers recommendations related to drug/alcohol counseling and drug/alcohol abuse prevention for postsecondary school personnel who work with deaf or hard-of-hearing students. The paper discusses characteristics of the target population, the lack of appropriate treatment services, communication modes of the target population, cultural aspects of deafness, prevention approaches of colleges and universities, the need for support groups, and types of substances being used. A comprehensive chemical health model is recommended that includes program development, intervention, education, and training. (JDD)

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SAYING NO IN COLLEGE: HOW TO DEAL WITH SUBSTANCE ABUSE

AMONG DEAF AND HARD OF HEARING STUDENTS

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The Drug Free Schools and Communities Act of 1986 defines a child at high risk of developing a drug or alcohol problem if he or she has "experienced mental health problems or long-term physical pain due to injury." The vulnerability of these individuals is also recognized by the Federal Office of Substance Abuse Prevention (OSAP), which puts "youth with disabilities" in a category of greater risk for developing an abuse problem along with other groups such as "children of substance abusers," "economically disadvantaged youth," "school drop-outs," and "pregnant teens." To date, there have been two residential school studies (Isaacs, Buckley and Martin, 1979; Johnson and Locke, 1978) and one state wide study (Boros, 1981) estimating the incidence of substance abuse in the deaf population. These studies suggest the incidence of substance abuse in the deaf community to be approximately that of the general population. This would mean there are at least 73,000 deaf alcoholics, 8,500 deaf narcotic addicts, 14,700 deaf cocaine/crack addicts, and 110,000 deaf marijuana users (McCrone, 1982).

This paper will focus on recommendations related to drug/alcohol counseling and prevention for post-secondary school personnel who work with deaf or hard of hearing students. Many of the issues and suggestions that will be addressed could be generalized for all disabled or non-disabled students. Dennis Moore, Ed.D., from Wright State University, has announced the beginning of a five-state demonstration project funded by the Office of Substance Abuse Prevention to prevent alcohol and other drug misuse by young persons with disabilities. The project will investigate attitudes and behaviors of college students receiving services through campus disabled students services/offices. Research has found that the following traits are found in many disabled individuals who have a

substance abuse problem. Dysfunctional family system, seeks acceptance from peers, not accepting disability, and once out of high school uses SSI money for chemicals. Alcoholism has been called the lonely disease (Coleman, Butcher and Carson, 1980) and deafness has also been called the lonely handicap (Mindel and Vernon, 1971). The deaf alcoholic has a multifaceted problem because he/she must overcome the effects of the deafness and a disease which encourages isolation. It is imperative that part of the rehabilitation includes meeting deaf recovering counselors, or peers, and attending deaf NA/AA meetings.

Hearing impaired adolescent and young adult substance abusers suffer a particularly severe lack of appropriate chemical dependency treatment services for both outpatient and inpatient needs. A complex interaction among various factors within the deaf community and in the chemical dependency treatment delivery system exacerbate the difficulty of providing effective treatment. To date, the available literature focusing on the deaf young adult and adult population is limited, even scarce, as is the availability of treatment opportunities. Riverside Medical Center's Minnesota Chemical Dependency Program for Hearing Impaired Youth was the first inpatient center designed specifically to address the needs of this group.

The majority of hearing impaired adolescents and young adults use American Sign Language (ASL) as their preferred and most skilled mode of communication. Also, most use standard written English at a lower level of proficiency, often because it is their second language. Moreover, ASL, as a visually and spatially grounded language, does not provide a direct translation of English forms and the concepts represented by English vocabulary and syntax. Thus, knowledge about CD is not communicated very well in the deaf community--some key concepts and terms in CD treatment simply do not exist in the deaf culture. Beyond that, in

treatment settings designed for the mainstream, the language of communication is itself a barrier to participation among hearing impaired adolescents, in both the educational therapeutic and peer interaction dimensions of any well-designed program. In short, treatment is based on a level of English and "talking" that is simply not possible for many hearing impaired adolescents. The severe cognitive and affective shortcomings of treatment programs extend to deaf persons when the language of treatment is English and the language of meaningful use is ASL.

Deaf culture has always had a highly active "grapevine." This contact with each other on crucial news has helped to offset the lag in information flow. Most CD treatment and A.A. meetings must reinforce repeatedly such basic concepts as group function and confidentiality with greater frequency than would be the case in a mainstream group. The accumulation of such differences makes effective treatment of the hearing impaired adolescent uniquely problematic, especially when the mainstream treatment program is not built on the same cultural bedrock as are the lives of those hearing impaired individuals in treatment.

When providing alcohol/drug focused programming to deaf and hard of hearing individuals, it is important to take into consideration the following components: the cultural aspects of deafness; communication modalities; access to recovering deaf role models; access to deaf and/or interpreted AA/NA meetings; eliminate feelings of isolation; provide materials in American Sign Language on videotape and modified written English. Materials are also needed that focus on assisting students in developing assertiveness and social competencies, improving self-esteem, and strategies for resisting negative peer pressure. Many of the issues a deaf or hard of hearing person brings related to drug/alcohol dependency are the same as other disabled and non-disabled individuals. The grief and loss

process, family dynamics, and the denial cycle are all there. Steitler (1984) examined drug and alcohol abuse among disabled individuals. Suggested reasons for the abuse of substances among the disabled population included: 1) easy access to drugs and widespread resistance among educators, parents and others to recognition of the warning signs; 2) abuse of substances occurs in an attempt to manage frustration and anxiety; 3) disabled people are an oppressed minority, and alcohol and drugs promise numbness and relief; 4) substance abuse may result from medical intervention and the rehabilitation process.

Researchers have also found that deaf individuals who are abusing chemicals have similar characteristics to each other. According to Grant, et. al. 1983, deaf alcoholics frequently have little trust in themselves or in others. Adolescent deaf abusers tend to be more submissive to peer pressure, and dependent on the opinions of others; and they exhibit poor impulse control, poor communication skills, depression, immaturity and feelings of isolation and inferiority. We need to begin to identify the potential abuser at an early age. It is possible to use "at risk" characteristics to help make some determination. Timothy Titus, M.P.H., of Riverside Medical Center, has developed a Risk Chart that can be used by counselors or other personnel to help determine when an individual might be at risk for chemical dependency. The chart is broken down into the following categories: 1) Adolescent's relationship to past (drug/alcohol history, problems in family, history of loss); 2) Adolescent's relationship to self (perceptions of personal capabilities, perceptions of personal significance, perceptions of having control over environment); 3) Adolescent's relationship to alcohol/drug use (age and grade of first use, response and pattern of use); 4) Adolescent's relationship to peers (ability to build and maintain friendships, pattern of friends' alcohol/drug use, adolescent's response to peer pressure);

5) Adolescent's relationship to family (family involvement, parents' response to adolescent's alcohol/drug use, parents' and siblings' pattern of alcohol/drug use); 6) Adolescent's relationship to community (the adolescent's sense of belonging, the community's message about alcohol/drug use, community's awareness and response to the adolescent's alcohol/drug use.) Each category is rated in the low, moderate or high risk area. This kind of instrument could be revised and utilized with the young adult population.

Many deaf and hard of hearing young adults attend Gallaudet University, National Technological Institute For The Deaf (NTID), California State University at Northridge (CSUN), Seattle Community College, Waubensee Community College, University of Tennessee at Knoxville, St. Paul Technical College, and other post secondary institutions that have specialized programs or support services for the hearing impaired. When many deaf and hard of hearing individuals who have attended mainstreamed programs go to one of these institutions, many social doors are opened. Unfortunately, part of that "door" includes using drugs/alcohol. When surveying a number of schools that enroll a large number of deaf or hard of hearing students, very few had prevention programs in place that focus on drug/alcohol education. When a student decides to attend Gallaudet, it is especially unique because everyone on campus is able to communicate. Often, it is the first time that the student has had completely open communication and once some individuals begin to allow using drugs/alcohol to take over their life, grades often go down, disciplinary action occurs, and they are kicked out of school. Until recently, Gallaudet University, like many post-secondary institutions, didn't have a system in place for students who have drug/alcohol related incidents on campus. They have now begun a class which students are required to take after a first offense on campus. Gallaudet is beginning to take

a more aggressive approach to this problem, and it is hoped that more schools will follow. We need to be more proactive from elementary school on up instead of waiting for consequences to occur. One of the above mentioned schools is known by deaf individuals around the country as the best source for finding drugs, but that institution has made few attempts at focusing on this issue. Recently, more deaf and hard of hearing students have chosen to attend post secondary institutions in their community, or to focus on a particular major. It is imperative for us to provide support in the area of drug/alcohol education and counseling for these students.

While working at the University of Minnesota, I worked with several students suspected to be in need of chemical dependency treatment. There were only mainstream programs available, and few, if any, counselors to access who could complete an assessment on disabled students. I had worked with a student when he was in high school as well as at the University. He was a bright student, who would have good and bad quarters related to his grades. This was an individual who was raised oral (against the recommendation of school personnel), had a severe to profound hearing loss, good speech, poor lip-reading skills, and minimal sign language skills through high school. He was quiet, and had been a chronic alcoholic (as was his grandfather and brother) since high school. He had been able to keep his secret until several years into college when the pressure had gotten to him, and he had received two Driving While Intoxicated (D.W.I.'s), and was not able to attend because of his alcohol consumption. A referral was made to a local hospital known to be accessible to hearing impaired individuals. Unfortunately, the program was only two weeks in length, and while this individual was there, no other hearing impaired people were admitted. The same isolation that had existed throughout his life was

evident at the treatment program. Within three weeks of discharge, the student had convinced his vocational rehabilitation counselor, family, and myself, that if he went to NTID, the new environment, ability to communicate, etc., would solve his problems. He went to NTID, found those new "social doors," began using heavily, and left within one quarter. He worked in a grocery store, continued using and was picked up in his parked car--passed out. After several more occurrences when he had hit bottom, he went to the Minnesota Chemical Dependency Program For Hearing Impaired Youth to get information about AA meetings. Within a month, he called wanting to be admitted. He completed treatment, and continued on to an extended care program where he is currently residing. He is struggling, but still sober and lucky to have programs available to help him. This case history is no different from many of the students you may work with on a daily basis. The symptoms and issues surrounding chemical dependency are not always obvious. We need to include a drug/alcohol curriculum in all schools, and have personnel trained in assessment, referral and counseling.

Schools should sponsor support groups, Alcoholics Anonymous (A.A.), Narcotics Anonymous (N.A.), Children Of Alcoholics (C.O.A.), Alanon, Alateen, etc. that are geared for the deaf, hard of hearing, and other disabled students. A social worker at the Model Secondary School For the Deaf has been facilitating a C.O.A. support group for the past several years. The focus is a combination of education and counseling and has been quite effective. Coursework at the post-secondary level for individuals majoring in Chemical Dependency that focuses on working with disabled individuals needs to be developed and incorporated into training programs. At post-secondary schools that have a large number of deaf students, training programs in drug/alcohol counseling needs to be added. Deaf recovering individuals need to be hired to do outreach and counseling work within

the school systems and community. Federal funds need to be obtained for the training of counselors to work with deaf persons in the area of substance abuse. We also need to have public education commercials in sign language focusing on drug/alcohol abuse. Training in the area of drug/alcohol assessment and education should be required by personnel working with disabled individuals. Additional videotapes and written materials focusing on drug/alcohol education need to be made accessible for the deaf and hard of hearing. Congress appropriated \$250 million in 1988 for substance abuse prevention (Falck and Craig, 1988). How much of that funding benefits deaf children and adults? Within the United States we talk about how children, adolescents and young adults should learn to "Just Say No", but if deaf individuals don't have the opportunity to understand the benefits of saying no to drugs, how can we expect this approach to be effective. The McCrone study (ibid) indicates that deaf individuals are as susceptible as others to abuse problems. It is helpful to know the magnitude of these problems.

Within the last five years, studies have indicated that between 79 and 95 percent of college students use alcohol. While college students are the usual target of research, it is important to remember that the problem of abuse graduates along with the students in college. A person who is abusing alcohol is often confused with the alcoholic. While these both indicate problems with the use of alcohol, they are not synonymous. The alcoholic is a person who suffers from the disease known as alcoholism, an inability to tolerate alcohol in any amount. This disease afflicts millions, and requires long-term treatment. An abuser, on the other hand, is an individual who drinks to excess by choice. The majority of people who abuse alcohol are not alcoholics, but are persons who for some reason make irresponsible choices regarding their alcohol consumption.

Alcohol abuse can be recognized by its effect upon the user. Abuse can result in the disruption of personal relationships, vandalism, auto accidents, health problems, and changes in behavior such as missed classes, lack of concern over personal appearance, chronic hangovers, and blackouts. The National Council on Alcoholism defines Alcoholism as a chronic, progressive and potentially fatal disease characterized by tolerance and physical dependency or pathologic organ changes, or both. Generally, alcoholism is repeated drinking that causes trouble in the drinker's personal, professional or family life. When they drink, alcoholics can't always predict when they'll stop, how much they'll drink or what the consequences of their drinking will be. Denial of the negative effects alcohol has in their lives is common in alcoholics and those close to them. There is no known cure for alcoholism, but the disease can be arrested through complete abstinence from alcohol and other addictive drugs. Once abstinent, most alcoholics recover from the damage caused by their drinking.

There has been little research done at this time that focuses on specific information about drugs of choice or amounts used by hard of hearing and deaf high school or college students. McCrone's research showed that the percentage of disabled and non-disabled students have similar statistics. Other research has stated that in the "normal" population, one out of every ten individuals are chemically dependent, but among the disabled it is suspected that one out of every eight may be chemically dependent. A survey by the National Parents Resource Institute for Drug Education (PRIDE) found that the number of high school students using alcohol, marijuana and cocaine has declined, but the percentage of users reporting high levels of intoxicification has risen. The survey of 392,000 students in 38 states showed that the number of high schoolers claiming some use of beer during the past year dropped in 1988-89, as did the use

of distilled spirits, marijuana, and cocaine. However, the number of users reporting they got "high" from alcohol and cocaine rose. Similar trends were noted in use of alcohol and other drugs, especially cocaine, in the junior high age group. Based on its data, PRIDE estimates that 690,000 American students in grades 6-12 tried cocaine in 1988-89, and some 223,000 used cocaine weekly or daily. (From Prevention File, Winter 1990)

In 1989, the University of Minnesota conducted a Alcohol and Drug Survey. I will compare some of their results to statistics we have observed with clients who have gone through The Minnesota Chemical Dependency Program for Hearing Impaired Youth during the past year and a half. The University of Minnesota survey did not identify whether students were disabled, but the statistics are useful when determining the need for chemical dependency services on all campuses for all students. The 7 page survey was mailed to a random sample of 1,000 students on the Twin Cities Campus; returns were received from 814 students, yielding an 81% response rate. The first area focused on Alcohol use and determined that 83% of all students drink alcoholic beverages. Although below the legal drinking age, four-fifths of all 18-20 year olds drink alcoholic beverages. Beer is the alcoholic drink of choice by the University of Minnesota students as well as on a national basis. 36% of all students have been drunk at least once in the past month with the incidence of drunkenness highest among 18 and 20 year olds (65%) and next highest among 19 year olds. The percentage of students who have driven while drunk at least once in the previous month dropped from 15% in 1985 to 11% in 1989, but at 11%, 4,000 University students are driving while drunk each month. One objective of the 1989 survey was to establish a benchmark before the change in the drinking age against which changes in drinking could be measured. The results from the 1985 survey were compared

with the 1989 survey to determine if there was any change as a result of the legal drinking age going from 18 to 21. The results indicate a slight decline in the number of 18 and 19 year olds who drink and no reduction in the percentage of 20 year olds who drink. Although underage students are drinking less frequently, they are drinking larger volumes which means that there is an increase in the percentage of underage students who get drunk.

Related to overall drug use, the percentage of students who have used mood altering drugs has dropped from 52% in 1985 to 44% in 1989. Marijuana is the second highest drug of choice, after alcohol, but much less in usage. Current cocaine use has dropped from 3.8% in 1985 to 0.8% in 1989.

Special analyses show that equal percentages (43%) of men and women have been drunk at least once in the past month and that there is a significant relationship between drinking behaviors and drug use on the one hand and academic performance on the other. 61% of individuals who got drunk at least once the past month had a GPA of under 2.5, while only 23% of those individuals had a GPA of 3.5+. Fraternity and sorority members tended to be highest in being drunk, using fake ID's, driving while drunk, and use of drugs.

Based on data collected with the deaf and hard of hearing individuals we have served, alcohol tends to be the primary drug of choice, usually used in conjunction with marijuana and/or cocaine. The majority of our patients have experimented with a variety of drugs, but we have seen an increase in clients who have been addicted to crack, cocaine, and several who have snorted gasoline. Over 90% of our patients have been males from throughout the United States and Canada which does not match the statistics gathered for the general University of Minnesota population. This is not to say that more deaf and hard of hearing males are chemically dependent, but the field of deafness related to chemical

dependency is about twenty years behind the general population in service provision. If we were to review trends from twenty years ago, we would find primarily men being treated for alcoholism because their drinking was more visible. This is not to say that women weren't alcoholics, but their drinking occurred privately in their home. We assume that in the future the trends in the deaf community will parallel the general population. The majority of our patients have been between the ages of 21-25 and have unsuccessfully attempted some kind of post-secondary schooling. We have had a number of dual diagnosis and minimal language referrals that have presented unique challenges. We need to provide disabled students at the post-secondary level with a comprehensive chemical health model that includes program development, intervention, education, and training.

Program Development - Each post-secondary institution should establish a drug/alcohol task force that will explore issues related to this area. Policies should be developed focusing on identification, intervention, disciplinary actions, academic review, alcohol/drug violations, referral process, etc. This group should also develop procedures and services on campus available to all students.

Intervention - Student assistance programs that include peer counselors should be established on each campus. Crisis intervention and assessment for potential chemical dependency should also be available. There should be re-entry support and aftercare services for individuals going through treatment. Educational sessions focusing on DWI's, alcohol/drug education, stress management, assertiveness skills, and time management should be offered campus wide. Campuses should host AA, NA, ACOA, Alanon, etc., for disabled and non-disabled students.

Education - Each campus should host activities such as drug/alcohol awareness week or other campaigns focusing attention to this issue. Training should be provided to faculty, staff and students related to drug/alcohol education. Training programs to prepare peer counselors in areas related to: signs and symptoms of chemical dependency, available resources in the community, development of a basic drug/alcohol education curriculum that can be offered throughout the campus, working with disabled students should be implemented. Establish a resource center with chemical dependency materials available which includes local and community information. Participate in presentations for freshmen orientation, residence halls, athletic teams, sororities and fraternities, and academic classes.

Training - Develop programs that provide training in the area of drug/alcohol counseling and education to student services staff, resident directors, resident assistants, faculty, coaches. Offer a basic training program in signs and symptoms of chemical dependency.

Personnel from the offices that serve disabled students should be prepared to add information in all areas that focus on unique issues when working with each specific disability group. It will be imperative for all individuals working with deaf or hard of hearing clients to know how to work with an interpreter, cultural issues related to deafness, language barriers, etc.

Chemical dependency is grounded in the deaf culture. Treatment is needed and must be designed by persons who live in the deaf community and/or have training in the psychological, social and communication needs of members of the community who are chemically dependent. There are very few existing halfway houses, extended care facilities, outpatient or inpatient programs that are accessible to deaf and hard of hearing persons. We need to work together to have

the drug and alcohol problem in America become a focus for the Deaf Community. As professionals, it is our responsibility to educate our colleagues within this field about their need to address this important and neglected issue. The most powerful tool in bringing about this support and change is through education, which you can give and receive both formally and informally. The enhancement of existing services in addition to the development of new programs, materials and training opportunities is urgently needed. This will only happen when we have the support and recognition of the deaf community, elementary and secondary schools, federally funded post-secondary programs, universities, and chemical dependency providers who will serve deaf and hard of hearing persons.